Utah Telehealth Network

September 8, 2010

Federal Communications Commission
Washington DC 20554

Dear Chairman Genachowski and Commission Members:

Re: 02-60 Notice of Proposed Rulemaking

I would like to begin my comments by applauding the FCC's commitment to ensure broadband access to health care providers. As the program manager for the Utah Telehealth Network since 1996 and the project coordinator for our RHCPP project, I have had firsthand experience with your support of rural health care since its inception. We have utilized the Rural Health Care Division discount program since 1999 to connect remote rural health care facilities hundreds of miles and several hours away from urban medical centers. Without it, there wouldn't be a Utah Telehealth Network. We also are participating in the Pilot Program. Although we have been beset by challenges in getting it off the ground, we appreciate the program and believe that it is absolutely essential to the widespread adoption of health information technology, including telemedicine, electronic health records, and clinical health information exchange.

Here are my comments on the NPRM:

1. Expansion of the interpretation of "eligible health care provider" to include acute care facilities, administrative offices, and data centers is a great step forward and more in line with the way health care is actually delivered today.
2. Physicians who own their own practices are considered "for-profit" but those practicing in rural areas provide a valuable service to their communities. It would be helpful if there could be a mechanism by which physician offices, especially those who serve rural and/or underserved populations, could be considered eligible health care providers.
3. Support for administrative costs would be beneficial. It has been a challenge to manage the RHCPP project over and above an already busy full-time job. I would recommend a percentage of the total project cost, payable as the project is implemented, up to a maximum of the proposed $100,000 per year. At the same time, the FCC and USAC should take steps where possible to streamline the process. In the RHCPP, one of the challenges has been trying to understand exactly what is being asked. One suggestion would be to very clear about reporting requirements combined with electronic templates.
4. In Utah, options in rural, even remote areas, are not limited to mass market or dedicated access Internet; dedicated Ethernet is offered in most rural communities. Broadband is not **unavailable**, but it is **unaffordable** in many rural areas where there is a single provider, a lack of critical mass of customers, and no incentive for competitors to come into the market.
5. It appears that the FCC is encouraging health care providers to own their own infrastructure (dark fiber, etc), but that is a huge burden of responsibility for health care providers and not our area of expertise. It is likely to result in infrastructure silos, making it more challenging to share infrastructure investments with education, states, etc. It would be very costly to maintain and support.
6. Our preference would be support for the model being implemented for our RHCPP project, whereby we have an essentially private network running over commercial carrier facilities, with our own NOC

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to manage our network and to coordinate the use of VPNs and other tools to support the clinical and business operations of our health care providers. This model, we believe, facilitates economies of scale, provides more business for existing carriers in remote regions, and shifts the burden to them to keep circuits up.

7. Our preference is to use relatively short term contracts with vendors. I am loathe to sign 10 year contracts. With the amount of funding flowing into the state from ARRA and other infrastructure projects, costs for broadband should decline over time. Locking into long term contracts could result in overpaying for services.
8. The NPRM indicates a preference to limit future funding for rural sites only. While I support the preference for rural health care facilities, there other factors requiring consideration of inclusion for at least some urban facilities. Our telehealth network hub, for example, is located in an urban area and has backbone costs to the carriers. These network costs will be passed on to network members, the majority of which are rural health care providers. Other circumstances meriting consideration of urban discounts would include urban HCPs supporting underserved populations (such as FQHCs), urban sites geographically distance from major medical centers (for example, urban St George is 303 miles – one way - away from Utah's Trauma 1 centers and specialty services in Salt Lake City); urban data centers and administrative offices that support rural health care.
9. Finally and most importantly, I ask the Commission to reconsider the proposed 50% discount for MRC for rural. The Universal Service program was designed to level the playing field for rural health care providers, but the 50% discount would result in high costs for remote rural sites and increase their chances of not continuing beyond the RHCPP pilot period. Based on an exhaustive 12 month competitive bidding process for our RHCPP project, here are the most competitive prices for dedicated Ethernet services as quoted by the vendors and with the proposed 50% discount:

Bandwidth	Quoted MRC for urban site	Quoted MRC for rural site near urban area	Quoted MRC for remote rural site ("frontier")
5 MBPS	$575	$575	$1,395
5 MBPS w/50% discount	N/A	$287.50	$697.50
10 MBPS	$575	$575	$1,800
10 MBPS w/50% discount	N/A	$287.50	$900
20 MBPS	$575	$575	$2,100
20 MBPS w/50% discount	N/A	$287.50	$1,050
50 MBPS	$650	$650	$3,000
50 MPBS w/50% discount	N/A	$325	$1,500
100 MBPS	$850	$850	
100 MBPS w/50% discount	N/A	$425	N/A

A 50% discount applied to a 5 MB connection for a remote rural health care provider will cost more that a 50 MB connection for an urban health care provider. In addition, there are transport or backbone costs to aggregate the rural traffic back to urban areas, so the cost to rural sites will be even higher. I would strongly request that the FCC level the playing field for rural sites by allowing broadband projects to apply a rural/urban difference, which is currently available in the "regular" RHCD program for T1 lines, and/or continue the 85% discount for the most disadvantaged sites.

We are fast approaching the day when health care providers will have to have affordable broadband access in order to provide quality, cost effective care to their patients. Thank you to the FCC for your thoughtful attention to this vital issue and for the opportunity to submit input. Please feel free to contact me if you have questions or require further clarification.

Respectfully,

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